

CASE NO. 06-CV-673-GKF-FHM

**IN THE UNITED STATES DISTRICT COURT FOR
THE NORTHERN DISTRICT OF OKLAHOMA**

UNITED STATES OF AMERICA

Plaintiff,

vs.

STATE OF OKLAHOMA, et al.,

Defendants.

**OBJECTION TO PLAINTIFF'S MOTION FOR PRELIMINARY
INJUNCTION AND BRIEF IN SUPPORT**

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**UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF OKLAHOMA**

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| UNITED STATES OF AMERICA |) | |
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| Plaintiff, |) | |
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| STATE OF OKLAHOMA; et al. |) | |
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| Defendants. |) | |

**OBJECTION TO PLAINTIFF’S MOTION FOR PRELIMINARY
INJUNCTION AND BRIEF IN SUPPORT**

INTRODUCTION AND STATEMENT OF THE CASE

In March of 2004, the United States began its investigation of the conditions and treatment of youth at the LE Rader Center (Rader), which is operated by the Office of Juvenile Affairs (OJA). During its investigation, the United States obtained documents dating back to November 5, 2003 and up through 2005. In June of 2005, the United States Department of Justice, Civil Rights Division (DOJ) sent a “findings” letter to the State outlining concerns relying, at least in part, on unconfirmed reports of incidents occurring at Rader that it considered to be in violation of the Rader residents’ constitutional rights. In response, the State pointed out the fallacies of many of their conclusions, with supporting documentation. (See Letter from Asst. A.G. Clyde Kirk - Exhibit 1, and supporting documentation is filed separately under seal as Exhibit 2). For example, of the forty-six (46) incidents cited by DOJ, the State identified investigations which determined that no caretaker misconduct occurred in nineteen (19) of those instances. In another ten (10) instances, there was not even a question of staff misconduct but the juvenile misconduct was investigated and disciplinary action taken when determined appropriate under Rader’s existing policies. In each instance in which

an investigation revealed that youth had been mistreated, disciplinary action had been taken, which frequently resulted in the termination of the involved staffs' employment. (Exhibits 1 & 2).

Also, in response to the "findings" letter, the State identified steps it had taken to remediate some of the problems identified in DOJ's findings letter, which included the installation of a Mental Health Stabilization Unit at Rader for OJA youth (Exhibit 1 at p.3), the implementation of uniform reporting policies, (Exhibit 1 at p.12) and the execution of a contract with the chief child psychiatrist for the Oklahoma Department of Mental Health and Substance Abuse Service (ODMHSAS) to provide on-site care and consultation (Exhibit 1 at p.4). The State identified future plans for a new security fence and employment of a "gang services" expert to provide training in the area of juvenile gangs. (Exhibit 1 at p.14) The State rejected DOJ's faulty conclusion that there was a pattern and practice of violating the Constitutional rights of the Rader youth, but articulated its desire to do more than provide the constitutionally minimal care of the youth and welcomed any financial aid and technical assistance available. (And, which DOJ was legally obligated to provide) 42 U.S.C. § 1997b(a)(2)(A). (Exhibit 1 at p.14)

Rather than responding with assistance, DOJ sought and was granted access to Rader for a site visit. At the conclusion of the site visit, all parties met and reviewed DOJ's concerns. While OJA acknowledged many of DOJ's concerns and immediately began to rectify problem areas, DOJ refused to provide the written recommendations of its experts, much less provide any financial aid or technical assistance to support the State's efforts.¹ Thereafter, the State was offered an ultimatum

¹ Until mandatory disclosures required by FRCP 26(a)(1) Plaintiff's counsel of record had steadfastly maintained that no expert reports were ever prepared as a results of their investigation or inspection, even after repeated requests for their production pre-lawsuit. However, upon disclosures the Defendants were provided several documents which look suspiciously like expert reports. Plaintiff's counsel has now asked at least two (2) state witnesses in their depositions if they

of signing a consent decree or being sued. The consent decree would required OJA to spend thousands of dollars out of its budget to on DOJ bureaucracy as opposed to actually providing and improving services and conditions for the youth at Rader. Rather than give into such threats and waste it precious resources, OJA refused to be intimidated and continued to focus its work on improving the conditions at OJA and Rader. Since the site visit OJA has taken the following steps:

- Hired new Executive Director, Gene Christian, in August 2006;
- Implemented new suicide policies recommended by DOJ;
- Adopted the Prison Rape Elimination Act (PREA) which is designed to reduce the incidence of sexual assaults in secured settings and improve the investigations OJA performs into such occurrences;
- Emphasized and continue to emphasize to all staff on the need to comply with new uniform reporting policies and report all incidences occurring at the Center involving a possible use of force;²
- Relocated the sex offender unit within Rader to a unit where youths' activities could be more closely monitored and their movement restricted, when necessary. The population of the youths on the units was also reduced to afford better services and more effective monitoring;
- Installed a new camera system to provide greater visual observation and monitoring;
- Reduced the Rader population to accommodate for the limited staff available to provide services and security for the youth;
- Engaged and continue to engage in efforts to hire staff for the facility;
- Installed and continue to install mirrors in youth's residential areas to provide greater observation and monitoring;

had reviewed expert's reports among other documents. (Depositions of Jerry Nunn and Matt Bellinder taken on September 12, 2007 - transcripts unavailable.

² The implementation of this policy has resulted in an increase in the number of *reports* of incidences occurring at Rader. This is not indicative of an increase in violence - confirmed incidences. It simply is indicative of OJA's efforts to assure all possible allegations of abuse and/or neglect are investigated.

- Installed *Guardis* - an electronic system which requires staff to electronically sweep monitors to assure that their rounds are being performed as required by OJA and Rader policy, ie. staggered staff patrols;
- Hired new Superintendent Everett Gomez at Rader³ (See Affidavit of Gene Christian attached as Exhibit 3).
- Reduced the use of restraint by instilling a philosophy of extended de-escalation. (See Deposition of Everett Gomez at page 42 - 45, relevant portions of which are attached as Exhibit 4)

Still more interested in litigation than resolution, DOJ now pursues a preliminary injunction citing exigent circumstances which it has been aware of for years in certain instances - more than two years after its “findings” letter; more than one and one-half (1½) years after its first site visit; and eight (8) months after filing its lawsuit. The relief it seeks is inappropriate. Further it is unnecessary as it fails to acknowledge the changes the State has implemented and will do nothing to actually promote the safety and welfare of the youth at Rader. As will be demonstrated, OJA is already doing more than three quarters of the actions DOJ asks the Court to mandate through preliminary injunction.

A review of the vague relief DOJ asks the Court to impose reveals its lack of understanding about not only the realities of the juvenile justice system but of the limitations on the Court’s power to create a perfect world. Apparently, DOJ is under the impression that somehow a Court order or preliminary injunction will rid the Rader Center of violence and negligence. The State invites DOJ to identify any community in the country that is free of violence and negligence. In reality, no child at Rader has committed suicide or died as a result of any assault/attack since OJA has assumed operation of the facility in 1995. (Exhibit 3; Deposition of OJA Chief Psychologist Dr. Steve

³ Gomez has been the interim Superintendent from July 1, 2007. He assumed the full position September 12, 2007.

Grissom at p. 14, ls. 5-24; p. 242-243, relevant portions of which are attached as Exhibit 5).⁴ Clearly, youth at the Rader Center are less likely to commit suicide or die than youth in the general population for the State of Oklahoma.⁵

This is not to say that the youth at Rader are not at risk from harm. The youths of Rader have all been found guilty of offenses that would be considered felonies, but for their age. The offenses range from homicide, to rape in the first degree, to possession and distribution of narcotics and weapons. As of September 5, 2007, the average age of the one hundred and fifty-five (155) residents was 17.43 years. One third of the residents at Rader are eighteen (18) years or older. One third of the population has a gang affiliation. The average number of felony adjudications for the residents is 3.6 with some having as many as 18 such adjudications. In total the residents have 551 felony adjudications and 222 misdemeanor adjudications including 237 adjudications for crimes against persons (including homicide), 57 sex crimes, 314 crimes against property, 69 crimes related to possession or distribution of drugs or alcohol and 30 crimes related to possession or use of weapons. (See Profile of a Rader Resident - 9/5/07 attached as Exhibit 7). Hence, keeping the peace in this population is no small task. However, as will be established, OJA does a commendable job with its resources to assure that the Rader youth are afforded reasonable care, treatment and security. A statistical analysis of the troublesome occurrences at the Rader Center reveals that Oklahoma is keeping its youth in custody as safe as youth in custody in its sister states.

In its motion, DOJ cites seventy-three (73) incidences spanning a period of two and one-half (2½) years to support its contention that Rader is in “system failure.” Without even addressing the

⁴ OJA assumed operation of Rader in 1995. (Exhibit 3)

⁵ See DOJ Report on Juvenile Correctional Facilities attached as Exhibit 6.

lack of foundation and gross exaggeration of many of these incidents, seventy-three incidents over this period of time is not indicative of inappropriate or otherwise unconstitutional patterns, customs or practices on the part of Rader.⁶ While OJA continues to address problems at Rader, whether those problems arise from an individual employee, youth, policy or lack of resources, in general, the vast number of Rader residents live a life that is free from harm in an environment in which their educational and mental health needs are met on a consistent, regular basis.

ARGUMENTS AND AUTHORITIES

PROPOSITION I

DOJ MUST BE HELD TO THE HIGH STANDARD APPLICABLE TO DISFAVORED PRELIMINARY INJUNCTIONS

“As a preliminary injunction is an extraordinary remedy, the right to relief must be clear and unequivocal.” *Schrier v. Univ. of Colo.*, 427 F.3d 1253, 1258 (10th Cir. 2005). It is within this Court’s discretion to deny DOJ’s request for a preliminary injunction, and such a denial will only be disturbed if that discretion is abused. *Summum v. Pleasant Grove City*, 483 F.3d 1044, 1048 (10th Cir. 2007). To obtain a preliminary injunction, DOJ has the burden to establish that:

(1) [the youth] will suffer irreparable injury unless the injunction issues; (2) the threatened injury ... outweighs whatever damage the proposed injunction may cause the opposing party; (3) the injunction, if issued, would not be adverse to the public interest; and (4) there is a substantial likelihood [of success] on the merits.

⁶ Some incidences will be addressed specifically in the text of this response. Attached as Exhibit 8 is a summary of the incidences cited by DOJ.

Id. Preliminary injunctions are intended “merely to preserve the relative positions of the parties until a trial on the merits can be held.” *Summum*, 483 F.3d at 1048. Because of this purpose and the extraordinary nature of preliminary injunctions, movants must meet “a heightened standard” when seeking one of the three historically disfavored injunctions: “(1) preliminary injunctions that alter the status quo; (2) mandatory preliminary injunctions; and (3) preliminary injunctions that afford the movant all the relief that it could recover at the conclusion of a full trial on the merits.” *Summum*, 483 F.3d at 1048 (citations and quotations omitted). When a movant seeks one of these historically disfavored forms of injunction, the movant must “make a strong showing both with regard to the likelihood of success on the merits and with regard to the balance of harms.” *Id.* The preliminary injunction requested by DOJ is subject to heightened scrutiny because it seek to alter the status quo and because the preliminary injunction they seek would grant much of the same relief they ultimately seek from a final ruling on the merits.

PROPOSITION II

LIKELIHOOD OF SUCCESS ON THE MERITS: APPLICABLE LEGAL STANDARD OF CARE

There appears to be some confusion in the Plaintiff’s brief as to the appropriate legal standard governing the care and safeguarding of “juveniles” at the Rader Center. This is not necessarily inconsistent with case law throughout the federal courts.

At one point in its brief, *citing Youngberg v. Romeo*, 457 U.S. 307, 324 (1982), DOJ contends that the Fourteenth Amendment reasonable safety standard applies to juvenile and their conditions of confinement. At two other points in its brief DOJ cites cases that clearly apply the

“deliberate indifference” standard from Eighth Amendment jurisprudence. Namely, in the area of contraband control the Plaintiff cites the case of *Berry v. Muskogee*, 900 F.2d 1489, 1498 (10th Cir. 1990) for the proposition that failure to enforce a contraband policy may amount to deliberate indifference. (DOJ Brief at p. 15) Again on page 26 on its brief DOJ also provides that mental health treatment, suicide prevention, and serious harm issues are governed by the Eighth Amendment standard established in *Estelle v. Gamble*, 429 U.S. 97 (1976).

Plaintiff also cites *Yvonne L. v. New Mexico Dept. Of Human Servs.*, 959 F.2d 883 (10th Cir. 1992) and *Hobock v. Grant County*, 216 F.3d 1087, No. 99-2194, 2000 WL 807225, at *2 (10th Cir. June 23, 2000) (table) for the proposition that youths in custody are examined under the Fourteenth Amendment for reasonable care. However, *Yvonne* is distinguishable from the present case because it dealt with juveniles placed in foster care homes.

More remarkable is DOJ’s reliance on the *Hobock* case , which is an unpublished Tenth Circuit opinion. It does in fact say that juvenile residents are governed by the Fourteenth Amendment safeguards. However, a closer reading reveals that the Tenth Circuit correctly, (as will be pointed out hereinafter) applied the deliberate indifference standard under the Eighth Amendment. “... To state a substantive due process claim, plaintiff must allege that ‘he was incarcerated under conditions posing a substantial risk of serious harm,’ and that the [county officials] were aware of and disregarded an excessive risk to inmate health or safety by failing to take reasonable measures to abate the risk.” Citing *Lopez v. LeMaster*, 172 F.3d 756, 760-61 (10th Cir. 1999) (quoting *Farmer v. Brennan*, 511 U. S. 825, 834 (1994)

Given the nature of the crimes committed by the juveniles housed at Rader, and the criminal versus non-criminal adjudication associated with such crimes, the facility is more like a penal

institution in many regards than it is a school for delinquent children. Many of the juveniles at the center have been adjudicated under the State of Oklahoma Youthful Offender Statute. 10 O.S. §7306-2.1 *et seq.* This is in the nature of a criminal conviction. 10 O.S. § 7306-2.8. Many of the children are over the age of 18 and can be “bridged” into the Department of Corrections for any number of offenses committed while at Rader. As pointed out in the introduction, the crimes for which juveniles are housed at Rader are serious felonies. Rader is considered a maximum/medium security facility and is accredited by the American Correctional Association. This seems to be one of few points that parties agree.

As one district court stated, “... the critical question in determining whether the Eighth Amendment or the Fourteenth Amendment is used to scrutinize claims of abusive treatment or conditions in state detention facilities is whether the plaintiff has been subjected to criminal or noncriminal detention...” *Reaves v. Honorable Peace*, 1996 WL 679396 (E.D. Va.), *citing Gary H. v. Hegstrom*, 831 F.2d 1430, 1432; and *H.C. ex rel. Hewett v. Jarard*, 786 F.2d 1080, 1080, 1084-85 (11th Cir. 1986). The U.S. Supreme Court apparently has not decided the appropriate standard applicable to juvenile institutions. *Indgraham v. Wright* 430 U.S. 651, 97 S.Ct. 1401 at 669.n27. This case is altogether missing from Plaintiff’s brief, but is cited in *Honorable Peace, supra*, and an 8th Circuit case of *A.J. by L.B. v. Kierst* 56 F3d 849 (1995).

All youth residing at Rader, whether they are “delinquents” or “youthful offenders,” have been adjudicated delinquent or found guilty of their offense beyond a reasonable doubt. 10 O.S. § 7303-4.1 *et seq.*; 10 O.S. § 7306-2.1 *et seq.* Though they are not referred to as felons, in light of the circumstances and legal proceedings which resulted in their placement at Rader, the Eighth Amendment prohibition against cruel and unusual punishment measured by the deliberate

indifference standard is most applicable. Furthermore, it is clear that while pretrial detainees, which is arguably the group most analogous to juveniles, are protected by the Fourteenth Amendment, their claims are analyzed pursuant to the Eighth Amendment. *Berry v. City of Muskogee*, 900 F.2d 1489 (10th Cir. 1990)

In determining what constitutes deliberate indifference, the U. S. Supreme Court has held that:

[a] prison official cannot be found liable under the Eighth Amendment for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.

Farmer v. Brennan, 511 U.S. 825, 114 S.Ct. 1970 (1994) at 1979 The Court emphasized that there is a requirement of “subjective recklessness” which must be found before an official can be held to have acted with deliberate indifference towards prisoners.

In order to meet a subjective recklessness standard, it must be shown that an official must have actually known of the significant risk of harm to the prisoner, or must be aware of facts from which the inference could be drawn that a substantial risk of harm exists and the official must also draw the inference. However, “[an] official’s failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment...” *Id.* at 1979.

In regards to the medical and psychological treatment issues in this case, DOJ must establish deliberate indifference to a serious medical need. See: *Estelle*, *supra*, at 104- 105. A serious medical need can be identified as one that even a layperson would realize needs a doctor’s attention. *Sealock v. Colorado*, 218 F.3d 1205 (10th Cir. 2000). Mere allegations of negligence in diagnosis or

treatment, or a mere difference of opinion concerning appropriate diagnosis or treatment, is insufficient to establish a constitutional violation. *Ledoux v. Davies*, 961 F.2d 1536 (10th Cir. 1992) Dissatisfaction with the care or treatment received, without more, is also insufficient to establish an Eight Amendment claim. *Johnson v. Stephan*, 6 F.3d 691 (10th Cir. 1993); *Ramos v. Lamm*, 639 F.2d at 575; *Smart v. Villar*, 547 F.2d 112, 114, (10th Cir. 1976) and *Jackson v. Fair*, 846 F.2d 811, 817 (1st Cir. 1988) Where the complaint is based upon inadequacy of treatment, the complaint fails to state a claim of deliberate indifference. *Daniels v. Gilbreath*, 668 F.2d 477 (10th Cir. 1982)

While the Plaintiff will probably maintain that the standard is one of reasonable care, it is relatively well settled that negligence is insufficient to establish *any* constitutional violation such as those complained of by the Plaintiff herein. See: *Daniels v. Williams*, 474 U.S. 327 (1986) and *Davidson v. Cannon*, 474 U.S. 344 (1986) Furthermore, the U. S Supreme Court has said that negligent conduct is one end of the scale and conduct amounting to a constitutional violation is at the other. *County of Sacramento v. Lewis*, 523 U. S. 833 (1998).

Although DOJ has gone to great lengths to point out isolated events where some juveniles have been injured, it cannot establish any pattern or practice sufficient to demonstrate that the officials operating Rader are deliberately indifferent to their needs or even that the conduct complained of is unreasonable. In fact nowhere in its brief does the Plaintiff offer to define "...a pattern and practice."

42 USC § 1983 jurisprudence teaches that pattern and practice concepts sufficient to establish liability consist of conduct or practices that are "persistent and widespread" to the point of becoming "...well settled as to have the force of law..." *Monell v. Department of Social Services*, 436 U.S. 658,

98 S.Ct. 2018, 56 L.Ed.2d 611(1978) at L.Ed.2d at 635-36. If so found, the persistent widespread practices amount to a custom of the entity.

Two cases of particular pertinence hereto are *Gates v. Unified School Dist. No. 449 of Leavenworth County, Kan.*, 996 F.2d 1035 (10th Cir. 1993) and *Jane Doe A v. Special School Dist. Of St. Louis County*, 901 F.2d 642 (8th Cir. 1990) in both cases the Courts dealt with alleged unconstitutional policies based upon improper conduct of school officials.

In *Gates*, a plaintiff alleged that she had been subjected to sexual assaults by one of her teachers. Apparently, the school authorities had been on notice that the teacher had at least one prior act of sexual misconduct with a student. *Id*, at p. 1037. Furthermore, the plaintiff alleged that the school authorities had failed to adequately investigate the previous event. However, there was not sufficient evidence presented to establish that the defendants had notice of the previous incident or otherwise acted with deliberate indifference by failing to investigate rumors of misconduct.

For purposes of the present case, the Tenth Circuit stated in *Gates*, that to prove an unconstitutional policy or custom of failing to receive, investigate and act upon complaints, that the plaintiff must demonstrate that:

- (1) the existence of a continuing, persistent and widespread practice of unconstitutional misconduct by the school district's employees;
- (2) deliberate indifference to or tacit approval of such misconduct by the school district's policymaking officials (board) after notice to the officials of that particular misconduct; and
- (3) That the plaintiff was injured by virtue of the unconstitutional acts pursuant to the board's custom and that the custom was the moving force behind the unconstitutional acts....

Likewise, in the Eighth Circuit opinion in *Jane Doe A.*, the Court there did not find the existence of widespread unconstitutional practices. This was true even though some of the

individually named defendants had received complaints that a bus driver employed by the school district had received complaints over a two year period that he driver had been acting inappropriately toward several handicapped children on the bus. In finding that there was no unconstitutional practice, the Court identified the same criterion used later by the Tenth Circuit in *Gates, Id.* The Appeals Court also noted that a failure to act by administrators upon notice of some incidents was more appropriately characterized as negligence and not deliberate indifference. "...[S]uch negligence does not implicate the fourteenth amendment protections." *Id* at 901 F. 2d at 646, *citing Daniels v. Williams, supra*, and *Davidson v. Cannon, supra*, (citations omitted). *See also: Board of County Comm'rs of Bryan County, OK., v. Brown*, 520 U.S. 397, 117 S.Ct. 1382 (1997), where a single incident of failure to screen an employee is not sufficient to establish pattern or practice.

As mentioned above, and as the exhibits further demonstrate, there are policies in place to deal with every aspect of a confined juveniles life while at Rader. (Exhibit 3) Juveniles are screened when they arrive at Rader and a treatment plan is established. (Exhibit 5 at p. 110, l. 7 - p. 111, l.15; Exhibit 10 at p. 13, l.19 - p. 134, l.) Their activities are monitored by trained staff. While there have been problems with staffing shortages, OJA has reduced the population of Rader to assure that proper quotas are maintained and staff is not stretched beyond their capacity. (Exhibit 3) If and when it is determined that staff have failed in their duty, discipline occurs. If and when deficits in Rader's policies or procedures are identified, changes are made.

Interestingly enough, DOJ continues to insist that the Rader Center is derelict in its attention to the potential for suicide among its youth. What is remarkable about this is that DOJ is well aware that there has never been a successful suicide attempt at Rader. DOJ has been aware of this at least since it conducted its much ballyhooed inspection of the facility in November, 2005. One of the

inspecting experts working on behalf of DOJ opined in his report immediately following the inspection that while there was room for improvement, the Rader staff should be commended for the lack of actual suicides. (Report of DOJ Lindsey Hayes at p. 30, relevant portions of which are attached as Exhibit 9)

Juveniles arriving at Rader are medically screened by staff. If there is any indication of potential for suicide the juveniles are referred to the mental health unit. (Exhibit 10 at p. 234, l. 13 - p. 239, l.1) The mental health unit is staffed by psychological clinicians with sufficient training to determine if the juvenile poses a suicide threat. Rader further contracts with a psychologist and psychiatrist to be present at the facility weekly. (Exhibit 5, p. 31, ls. 8-22, p. 40, l. 12- p. 42, l.1) To further prove the point, mental health usually houses several juveniles who have exhibited the potential for suicide or self harm. (Exhibit 3) Further, as will be discussed in more detail, Rader recently had two youth with chronic self harming/suicidal behavior. While their stays were not without incident, both youth survived their stay at Rader.

This is certainly not the type of evidence that would indicate a lack of concern on the part of Rader or the State sufficient to meet the reasonable care standard mandated by the Fourteenth Amendment and much less the much more rigorous Eighth Amendment prohibition against cruel and unusual punishment. In regards to suicides in custodial facilities the Tenth Circuit requires deliberate indifference to a known, obvious risk or danger of suicide. *Barrie v. Grand County, Utah*, 119 F.3d 862 (10th Cir. 1997) (also cited by Plaintiffs’); *see also: Frohmader v. Wayne*, 958 F.2d 1024 (10th Cir. 1992).

The case of *Medina v. Bd. Of County Commissioners*, 2006 WL 898145, (Colo. 2006) considers the level of care, or duty, officials have to inmates under the deliberate indifference

standard. In *Medina*, an inmate told the jail staff that he was having “...crazy thoughts in his head” and was “thinking of killing himself.” After referral to mental health officials and a placement on suicide watch, the inmate, with the help of his lawyer, was voluntarily taken off of suicide watch. He then committed suicide by hanging himself. The district court determined that there was no deliberate indifference and granted summary judgment to the defendants. Relying on *Barrie*, the Court explained the standard of care as it relates to suicide:

...we conclude that in this circuit a prisoner, whether he be an inmate in a penal institution after conviction or a pre-trial detainee in a county jail, does not have a claim against his custodian for failure to provide adequate medical attention unless the custodian knows of the risk involved, and is ‘deliberately indifferent’ thereto... And the same standard applies to a claim based on jail suicide, i.e., the custodian must be ‘deliberately indifferent’ to a substantial risk of suicide...” at p. 869 (See also: *Estate of Hocker by Hocker v. Walsh*, 22 F.3d 995 (10th Cir. 1994))

As mentioned above the Plaintiff cites the Supreme Court case of *Youngberg v. Romeo*, *infra*, for the proposition that “...juveniles taken into State custody...” are entitled to a reasonable care standard. (DOJ Brief at p. 7) However, the *Younberg* case deals with neither juveniles nor a criminal confinement. In *Youngberg*, Ms. Paula Romeo had her 33 year old mentally retarded son civilly committed to a Pennsylvania state institution. Allegedly, her son suffered repeated injuries (63) because of the neglect of the facility staff.

The United States Supreme Court noted that this was a case of first impression where they considered “...the substantive rights of involuntarily committed mentally retarded persons under the Fourteenth Amendment...” Even though the Court considered the matter as a reasonable safe condition case, the court placed restrictions on that concept. The Court struck a balance between the rights of the committed mentally retarded and the legitimate interests of the state. *Id*, at 321. The

Court adopted the reasoning of the Circuit Court’s Chief Judge Seitz who determined that all that was required that the State had utilized professional judgment to treat those committed.

While DOJ failed to mention it, it is important to recall that Remco is limited to the involuntarily committed mentally retarded. In fact the Supreme Court pointed out that “[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish...” *Id* at 322. In determining whether the state has met its obligation in this regard and in this limited arena, the Court said that “...decisions made by the appropriate professional are entitled to a presumption of correctness. Such a presumption is necessary to enable institutions of this type—often, unfortunately, overcrowded and understaffed- to continue to function...” *Id* at 324.

Accordingly, under the standard of reasonable care advanced by the Plaintiff, its case in regard to Rader would fail. The instances provided by the Defendants are replete with examples of considered professional judgment in the safekeeping of juveniles at the facility. The Defendants do not concede that the standard advanced by Plaintiff for reasonably safe conditions is the appropriate one, but only that Rader meets that standard as well.

PROPOSITION III

IRREPARABLE INJURY

Plaintiff assumes that it will prevail on the likelihood of success argument and that the Court should likewise assume that irreparable injury is a certainty. However, Defendants do not agree with either conclusion and herewith have presented sufficient, credible evidence of actions and policies that meet or exceed the demands for remedy made by the Plaintiff. Plaintiff’s conclusory comments that there is an “overwhelming number of incidents..” is simply erroneous. Putting before the court

a number of unsubstantiated instances, many of which stand controverted, is not proof that “...injuries will continue without systemic changes.”

The fundamental flaw in plaintiff’s argument is not whether there will be specific instances of injury, perhaps even severe, but rather, will there be an ongoing pattern and practice that is deliberately ignored by the Defendants. DOJ establishes this standard in its brief. No one would argue that the Defendants can guarantee that all juveniles within the facility will be free from all harm. All that can be demanded is that Defendants do not disregard known substantial risks (i.e, *Farmer, supra*) or provide reasonably safe conditions. (*See: Youngberg, supra.*)

Plaintiff’s reliance on the *Kikumura v. Hurley*, 242 F. 3d 950 (10th Cir. 2001) is misplaced. In *Kikumura*, the singular prisoner alleged that he was denied pastoral visits sufficient to meet the needs of his religious views which incorporated both Buddhism and Christianity. From the facts of that case there was no doubt left that not only were the Federal Bureau of Prison officials preventing such visits, but would deny them in the future. (*Id* at pp. 953-954) The Court decided that this amounted to a potential violation of the prisoners freedom of religion and remanded the matter. (*Id* at pp. 958-962) Accordingly, there was no question of a continuing violation of the constitution and irreparable harm.

Here in the Rader matter, the case is much different. There is no evidence that the Defendants conduct amounts to engaging in unconstitutional activity. To the contrary, the evidence is that Defendants have in the past, and are presently, taking steps to effectively deal with issues affecting the juveniles safety at the facility.

DOJ also pays lip service to the Tenth Circuit opinion of *O Centro Espirita Beneficente Uniao Do Vegetal v. Ashcroft*, 389 F. 3d 973 (10th Cir. 2004) for the proposition that the movant

must make “...a strong showing both with regard to the likelihood of success on the merits and with regard to the balance of harms...” *O Centro* also provided that “courts in this Circuit must recognize that any preliminary injunction fitting within one of the disfavored categories must be more closely scrutinized to assure that the exigencies of the case support the granting of a remedy that is extraordinary even in the normal course”. At 975 *O Centro* rejected language that the movant’s burden was “...heavily and compellingly ...” overruling that point from *SCFC ILC, Inc. v. Visa USA, Inc.*, 936 F.2d 1096 (10th Cir. 1991).

The Plaintiff in this case cannot meet the substantial burden associated with preliminary injunctions on either the irreparable harm or the likelihood of success elements.

PROPOSITION IV

RESPONSE TO PLAINTIFF’S SPECIFIC ALLEGATIONS

To be clear, Rader does not tolerate abuse or neglect of the youth in its custody. OJA staff are continually engaging in activities to prevent abuse and neglect from occurring and to determine the appropriate consequence or response to circumstances in which a youth is abused or neglected while residing at Rader. In responding to the specific allegations DOJ relies upon to support its contention of a custom, practice or policy, Defendants are not arguing that the incidences of abuse or neglect that did in fact occur, are justified. However, DOJ has exaggerated and/or misstated the facts in many circumstances. While the paucity of DOJ’s evidence standing alone may well be sufficient grounds for denying its motions for preliminary injunction, accurate information is essential for the Court to determine whether or not Defendants are engaging in practices, policies or customs which result in the systemic constitutional deprivations are the youth at Rader.

1. RESPONSE TO YOUTH ON YOUTH SEXUAL ASSAULTS:

To support its contention of systemic problems with youth on youth sexual assaults, DOJ points to seven (7) instances spanning a period in excess of a year.⁷ During this time frame the population of Rader exceeded the current population of 155 youth. In one of its instances, documents cited by DOJ reveal that there was no evidence to confirm sexual assault. Investigations from the Department of Human Services Office of Client Advocacy (OCA) and the Sand Springs Police Department regarding the July 13, 2006 occurrence (DOJ Brief at p. 9) determined that there was no evidence of sexual assault and that the rectal bleeding was likely from the youth's hemroids.(DOJ-1USv.OK077565)⁸. Finally, all seven incidents were investigated. In two of those incidents staff were found to have been neglectful in their duty. Appropriate discipline was taken in each situation. (Exhibit 8)

2. RESPONSE TO UNSUPERVISED SEXUAL MISCONDUCT:

Under the category of sexual misconduct, DOJ cites to seven (7) situations spanning a period of more than two (2) years to support their contention of systemic failure. Even assuming that each of these situations were confirmed (which they were not), seven situations occurring over a period of twenty-six (26) months in a population which exceeded 155 youths is not evidence of a systemic problem. DOJ also fails to advise the Court that at least five (5) of the referenced events occurred on the sex offenders unit (the Friendship Unit), OJA has reduced the population of that unit and relocated to a more secure area where the population could be more effectively monitored in June

⁷ The time referred to is the time between the earliest until the most recent incident, however the Court should consider that the total time frame of incidents DOJ cite, which is 2 ½ years (December 2004 through May 2007).

⁸ Documents attached to DOJ's motion will be referring as "DOJ - document #."

of 2007 (the Atlantis unit). (Exhibit 3) Hence, many of the concerns raised by those incidents have already been remediated by OJA.

Further, a thorough investigation of the May 6, 2006 incident (DOJ Brief at p. 12) could not confirm that any sexual misconduct had occurred, as the only witness was a youth who had a grudge against one of the youth allegedly involved in the misconduct.⁹ (DOJ - 1USv.OK077352). Even so, the staff member on duty who allowed the two youth to be alone was disciplined for her omission. In the incident occurring in August 2006 (DOJ Brief at p. 12), DOJ fails to point out that in this incident and at other times, other youth on the unit either create a distraction and/or that the youth frequently wait until a distraction has occurred which requires the staffs' attention, to engage in the sexual misconduct. (DOJ - 1USv.OK095481).

In the October 14, 2006 incident (DOJ brief at p. 11), in emphasizing that a staff member had left the unit to do laundry, DOJ misleads the Court regarding staffing. The investigative report reveals that while a staff member was off unit for a period of time in which the incident may have occurred, a Rader police officer was present. Further revealed in the documents is a very real question of whether sexual misconduct actually occurred or was simply a plot by the two residents involved to have one relocated. (DOJ - USv.OK077797).

Finally, all of these seven instances were investigated and staff misconduct was only confirmed in one. In that instance, staff received a written reprimand and placed on a corrective action plan. (Exhibit 8)

⁹ With regard to the failure to perform a medical examination (rape exam), surely DOJ is not advocating a policy change that would subject youth to intrusive rape exams based solely upon an allegation other youth who have motive to and could easily lie about the misconduct. The potential abuse of such a policy is obvious and would clearly lead to youth causing other youth to be unnecessarily subjected to intrusive rape examinations.

3. **RESPONSE TO SEXUAL RELATIONSHIPS BETWEEN RADER STAFF AND YOUTHS:**

Perhaps in its biggest stretch to establish systemic patterns, DOJ cites to three (3) instances spanning a year period, in which there was a possibility of “sexual relationships” between staff and youth. Each instance occurred on a separate unit and involved different individuals. If this were a systemic failure, evidence should be much more prolific. These are isolated instances in which OJA responded promptly and appropriately on all counts. DOJ points to no evidence OJA might have had *in advance* that would have alerted it to the employees’ potential for such misconduct.

Further, in the December 23, 2006 instance (DOJ Brief at p.12), an investigation did not confirm any sexual misconduct. The only misconduct confirmed was that the employee brought her cell phone on unit and allowed youth to use it. Indeed, even in that situation, the employment of the staff member was terminated. The “victim” to this misconduct was a sixteen year old who had been placed at Rader after being found to have committed Rape in the First Degree and Burglary II of a Residence. (Exhibit 7)

With regard to the November 27, 2006 incident (DOJ Brief at p.13), without excusing the individual staff’s absolute misconduct (which OJA took all the steps it could to see that the employee was criminally prosecuted), the Court must take into account that the “victim” in this instance was 17½ years old and had been convicted of lewd molestation and assault/battery with a dangerous weapon. (Exhibit 7) The staff was a 21 year old female, going through a divorce. A close review of the records cited by DOJ reveals that the youth was wooing this employee to get her to bring contraband to him. Her employment was terminated. (Exhibit 8)

While not an excuse for staff misconduct, these are not situations where predatory staff members are molesting young, vulnerable residents. The third victim is seventeen years old and found to committed several counts of domestic abuse. (Exhibit 7)

4. RESPONSE TO YOUTH ON YOUTH ASSAULTS:

If DOJ's counsel and experts actually believe that Rader can eliminate fighting at the facility, or that youth fighting at Rader and at times, simply attacking each other are indicative of systemic failure, then they are seriously mistaken.¹⁰ While every fight or attack is troublesome and investigated, the 26 incidences DOJ relies upon do not establish that Defendants have failed to provide a reasonable care much less that they are deliberately indifferent to the problem.¹¹

DOJ goes to great lengths to point out instances in which youth who have fought, remain housed on the same unit. This is not due to oversight or indifference. The professional staff at Rader are reluctant to move youth simply because of conflict. The relocation interferes with treatment and inevitably raises transition issues. Further, as treatment goals of most, if not all Rader residents include learning how to control anger and their impulsivity, removing residents from conflict, rather than helping them work through it is not favored by the professional staff. This is not to say that Rader does not remove or separate youth where the known danger is too great. (Exhibit 10, p. 82, l.8 - p. 83, l. 14; p. 201, l. 10 p p. 202, l. 9) Further, of those twenty-four incidents DOJ identified,

¹⁰ Its is doubtful DOJ can cite to any institution (or school for that matter) where fights do not occur and/or no child is bullied.

¹¹ As will be discussed further, it is interesting to note that the program DOJ seeks the Court to direct OJA to implement, would not even require the State to report assaults or uses of force that involve mutual combat. However, DOJ is also critical of a conclusion that mutual combat has occurred.

only three resulted in a finding of staff misconduct - those date 9/24/06 - DOJ Brief, those dated 9/24/06 DOJ Brief at p.17; 2/23/06 DOJ Brief at p.19; 4/14/06 Brief at p.20. In this category, only three of those incidents resulted in a finding of staff misconduct. Only one incident involved a weapon, which was a broom handle. Six of these assaults are more appropriately described as "mutual combat". (Exhibit 8)

5. RESPONSE TO STAFF RESTRAINTS:

Having to restrain a youth who is out of control is never pleasant and can lead to injury. New superintendent Everett Gomez has emphasized to his staff that employing extended de-escalation techniques will often obviate the need for a physical restraint. His emphasis of this philosophy has already significantly reduced the number of restraints used on residents. (See Exhibit 4 at p-42, l.6 - p.45, l.17). However, as DOJ has established, there are many violent youth at Rader. (See also Exhibit 7) Regrettably there are times that a physical restraint is absolutely necessary. DOJ misleads the Court in their depiction of the five (5) instances in nine (9) months where it takes issue with the use of force employed by Rader staff. In each instance in which it was determined that staff improperly restrained a youth, the staff was disciplined - in most instances terminated. Independent investigations of two of the five instances cited by DOJ did not confirm that staff engaged in abuse/misconduct (September 28 and March 15, 2006 incidents, DOJ brief at ps. 22 & 23). (Exhibit 8)

However, regardless of the inaccuracy of DOJ representations to this Court, even assuming that there were five (5) instances in nine (9) months in which different staff members did exceed the force necessary for the situation, such evidence is not sufficient to establish that Rader staff is engaging in a pattern, practice or custom employing excessive force. Exhibit 8

6. RESPONSE TO YOUTH ON YOUTH RESTRAINT:

While Defendants do not support the use of youth to restrain other youths, the three (3) isolated incidents in which youth did step forward to assist staff in subduing a volatile situation, again, is not indicative systemic failure. Further, DOJ conclusory statements that these isolated instances “constitute a gross and dangerous departure from professional standards” is consistent with its stated custom, pattern and practice in this case - that is to provide half truths and then conclude some standard (not yet revealed to Defendants or this Court) has been grossly violated.

Of those three (3) instances, only the one occurring October 30, 2006 (DOJ Brief at p. 23) resulted in a finding of staff misconduct. In that instance, the staff resigned. There was no confirmation of staff misconduct in the August 13, 2006 incident. And, a clear reading of DOJ’s documents regarding the final incident (October 16, 2005 - DOJ brief at p. 23) reveal that the youth instinctually began to help subdue a fellow resident who threw a VCR and tapes against the wall until Rader police officers arrived. There is no indication that his assistance was requested. He was simply being a good citizen. A trait OJA hopes to instill in all residences who pass through Rader’s doors. (Exhibit 8)

7. RESPONSE TO DANGEROUS CONTRABAND:

DOJ refers to two types of contraband in its motion: Seven (7) incidences involving drugs, tobacco or alcohol spanning a fourteen (14) month period; and six (6) instances involving homemade weapons spanning a eleven (11) month period of time. In light of a population exceeding 154 for most of this period and the demographic make up of this population, these numbers alone

cannot be considered excessive. Of course, OJA's goal is to maintain an environment free of contraband but this is no small task.¹²

With regard to the seven (7) specific instances involving drugs, tobacco or alcohol, a simple view of the facts contained in the documents establish that there is no pattern, practice or custom which is permitting this type of contraband to be smuggled on campus. In the one instance in which it was determined that a staff member might have been involved in providing alcohol, her employment was terminated. (See April 28, 2006 incident on DOJ Brief at p. 24)

Families including parents are encouraged and visit with their sons at Rader. In some instances parents have had to have their visitation privileges suspended for bringing contraband into the facility for their child. (See Exhibit 10 at p. 83, l.20 -p.84, l.10; p.202, l.13 - p.204, l.4; p.206, l.18- p.209, l.20)

Also in an effort to reduce the amount of contraband brought into campus, OJA is in the process of reconstructing its front gate security checkpoint to provide better control of contraband entering the facility from the outside. It is also in the process of replacing the canine unit assigned to Rader, who will be present on visitation days and during staff changes. Finally, the duties of the security guard assigned to the front gate are being reduced so that the person assigned will have more time to focus strictly on security and minimizing the opportunities for contraband to be smuggled into the facility. (Exhibit 3 at p. 6)

¹² It is ironic, DOJ fails to note the incident occurring during its second site visit in which one of its representative negligently left her purse (which contained contraband - cell phone) in an unsecured area. Her purse (including cash and cell phone) were stolen and as a result, the facility had to be locked down and residents searched until the purse and phone could be recovered. Review of the tape recordings indicate that DOJ's representative was unaware that her purse was missing for at least an hour. One would think that incidences such as this would enable DOJ to appreciate how difficult it is for staff to remain constantly vigilant. (See exhibit 11)

With regard to the “weapons” contraband, each incident involved homemade weapons made from items which are necessarily provided to the youth at Rader, ie. toothbrush, plastic eating utensils, and eyeglasses. Further, in each instance, these weapons were confiscated before there were used on other residents. (Exhibit 8)

8. RESPONSE TO SELF HARM/SUICIDE ATTEMPT INCIDENTS:

DOJ points to twenty-five (25) incidents it considers to be indicative of a systemic problem that Rader youth are not adequately protected from harming themselves or committing suicide. First and most significant is the fact is that there have been no successful suicides at Rader in all the years that its have been operated by OJA. A fact even DOJ experts find commendable!

Further with regard to these specific instances, eighteen of the cited incidents involved two youth who engaged in chronic destructive activity. Despite this activity, both youth survived their stay at Rader. (Exhibit 8) One of the youth had a propensity for ingesting anything he could put his hands on and was taken to the hospital for treatment and/or to determine whether or not he ingested the objects he claimed to have ingested. (Exhibit 8) All hospitalizations were a result of these two youths. Exhibit 8

Specifically, DOJ has overstated/misstated the facts in several instances. For example, the January 14, 2007 incident (DOJ Brief at p. 26) is the same incident referred to in their contraband section. The fact that a youth stole pills and may have taken methamphetamine, can hardly be considered self-harm or a suicide attempt. Contraband, yes. Suicide, no.

With regard to the October 27, 2006 incident (DOJ Brief at p. 27), the youth was not sent to the hospital for treatment. He was treated at Rader, which mainly required him to drink water. Exhibit 8. So too, the April 26, 2006 incident (DOJ Brief at p. 28) in which a youth did not want

to wait to have his stitches removed by Rader's medical team and attempted to bite them out with his toe, can hardly be considered a suicide attempt or behavior that should not result in a consequence.

DOJ makes much of the fact that in certain circumstances, youth are punished for behavior that could be considered "self-harming" and/or "suicide attempts." While it is true that those incidents are written up on the "Major Rule Violation" form, which may even have a recommended punishment, youth are not punished for this conduct unless and until it is reviewed by the treatment team. (See Exhibit 10 at p. 186, l. 18 - p. 192, l.22 & p. 245, l. 3 - p. 258, l. 24) Further, documents reveal that the most common consequence for youth who were punished for self harming behavior is "EBT" - early bed time or work detail. (Exhibit 8)

PROPOSITION V

RESPONSE TO REQUESTED RELIEF

To further examine how the Rader staff is neither deliberately indifferent or unreasonable in their care of juveniles, the Defendants offer the following responses to the points of "Requested Relief" sought by the United States:

1. To remedy the risk of future unconstitutional rapes and sexual assaults, the United States requested Defendants take the following steps:
 - a. Provide increased staff supervision and higher levels of supervision for youths with sexual offenses, predatory behavior, and other high-risk youths;
 - *OJA has transferred the sex offender unit of Rader from the Friendship Unit to the Atlantis Unit to provide increased supervision. The new unit provides individual rooms for each youth and under policy, the doors of the rooms can be locked if deemed necessary and justified. The number of youth in the unit have also been reduced to afford closer supervision. (Exh. 3 at p.6)*

- b. Control access and egress to sleeping quarters, including an alarm system to detect unauthorized movement and staggering the times for staff patrols;
 - *OJA is currently meeting with two vendors capable of providing alarm system (radio frequency identification devices) which would allow for the identification and notification of unauthorized movement and monitoring to problem areas such as bathrooms and bedrooms which are outside the staff's line of sight and camera system. Exh. 3 at p. 6.*
 - *OJA has already installed Guardis in many units which is an electronic system designed to ensure staff properly monitor all units and records the times and frequency of rounds. It has also installed an updated camera system Exh.3 at p.5-6.*
- c. Strictly monitor access to all bathrooms, showers, and other areas outside of staff line of sight;
 - See responses to 1a & b.
- d. Institute policies and procedures for prompt, adequate investigations of rape, sexual assaults, and inappropriate sexual relationships, irrespective of youth recantations;
 - *On September 9, 2006, OJA adopted the Prison Rape Elimination Act (PREA) (a copy of which is attached), which provides for the investigations of rape and sexual assaults. All such complaints are investigated by OCA as well. OJA has no ability to determine the manner of police investigations that are performed or the determination of the District Attorney. See Exh. 3 p. 3 and Item B.*
- e. Perform adequate background checks of staff, beyond the current intrastate database, to include a full NCIC check;
 - *OJA performs a complete fingerprint check by the FBI and the OSBI prior to employment. This has been the policy of OJA since January, 2005. An NCIC check (as requested by Plaintiff) is a lower standard than that currently being sued by OJA. OJA has attempted to use the NCIC check in the past but has been advised that OJA is not permitted to use NCIC checks as OJA is not a law enforcement agency. Exh. 3 at p. 9.*
- f. Define guidelines for inappropriate relationships between staff and youths, and institute clear guidelines for staff punishment;
 - *PREA, which OJA adopted on September 9, 2006, further defines inappropriate relationships between staff and youths. State statute further defines certain activities, including sex with a person in the legal custody of the state by an employee and school system as rape punishable by imprisonment in the Oklahoma Department of Corrections for up to fifteen (15) years. OJA refers all suspected incidents of this nature to the local district attorney's office for possible prosecution.*

- g. Institute an adequate confidential reporting system for staff to report sexual misconduct by other staff;
 - *DHS Policy 340:2-3-33 (a) provides for confidential reporting of said conduct. (See Item C to Exh. 3)*
 - h. Institute a toll-free hotline for youths, their parents or guardians, and/or their attorneys to contact and report allegations of sexual misconduct;
 - *The Oklahoma Department of Human Services has a toll-free hotline to report child abuse. It is the **Child Abuse and Neglect Hotline**: 1-800-522-3511. This number can be used and is used to report allegations of sexual abuse of Rader residents. See DHS Policy 340:75-3-14, Item D to Exh. 3.*
 - i. Institute a system to analyze data to target problem areas to prevent future occurrences;
 - *OJA is preparing an application for participation in the Performance-based Standards (PbS) for Youth Correction and Detention Facilities. PbS is used to as a self-improvement and accountability system to improve the quality of life for youths in custody. It sets national standards for the safety, education, health and mental health, security, justice and order within facilities and gives agencies the tools to collect data, analyze the results to desing improvements, implement change and to measure effectiveness with subsequent data collection.¹³ Exh. 3 at p.7.*
2. To remedy the unconstitutional risk of future harm from youth assaults, excessive uses of force and improper restraints, and contraband, the United States requested that the Defendant take the following actions:
- a. Provide increased staff supervision and higher levels of supervision for youths with predatory behavior and other high risk youths.
 - *See response to 1a. Additionally, the population of Rader has been reduced from 200 to 154 to lower the staff to resident ratio. See Exh. 3 at p.5.*
 - b. Control access and egress to sleeping quarters, including an alarm system to detect unauthorized movement and staggering the times for staff patrols.
 - *See response to 1a & b.*

¹³ OJA's current data reporting is more extensive than that required by PbS.

- c. Strictly monitor access to all bathrooms, showers and other areas outside of staff line of sight.
- *See response to 1a & b.*
- d. Institute policies and procedures for prompt, adequate investigations of assault and contraband.
- *OJA, Rader and the State of Oklahoma already have policies in place addressing Plaintiff's concerns: OJA Policies P-35-03-07 and Rader Policy RC30100.16 address the contraband issues (See Exh. 3 at p4 & Items H & I). OJA Rule 377:3-1-25, OJA Policy P-35-09-03, DHS Policy 340:2-3-33 and DHS Policy 340:2-3-36 address the assault and reporting of assault issues. (See Items E, F, & G to Exh. 3).*
- *Further there are plans to reconstruct the front gate security checkpoint to provide for better control of contraband entering the facility. OJA is also in the process to replace the canine unit who will be present during visitation and staff changes. OJA has also recently reduced the duties of the front gate personnel so that they will have more time to focus on security issues. Exh. 3 at p. 6.*
- e. Immediately and periodically, provide adequate competency based training for all staff on the proper use of force and acceptable restraints.
- *Training on CCMS, the adopted for of restraints utilized by OJA, is mandatory based upon the direction of the Director. (Rader Procedure RC10400.01, Item A to Exh. 3) See Exh. 3 at p. 3.*
- f. Adequately investigate all incidents of violence, use of force, restraints, and serious injuries, and take appropriate corrective action in response to the findings.
- *OJA Rule 377:3-1-25, OJA Policy P-35-09-03, DHS Policy 340:2-3-33 and DHS Policy 340:2-3-36 address the assault and reporting of assault issues. (See Items E, F & G to Exh. 3).*
- g. Immediately stop all youth on youth restraints
- *Current policy does not allow youth-on-youth restraints and OJA does not authorize such restraints. Exh. 3 at p.3.*
- h. Institute a system to analyze data to target problem areas to prevent future occurrences.
- *See response to 1i.*

- i. Institute a toll free hotline for youths, their parents and guardians, and/or their attorneys to contact and report allegations of assaults.
- *The Oklahoma Department of Human Services has a toll-free hotline to report child abuse. It is the **Child Abuse and Neglect Hotline: 1-800-522-3511**. See DHS Policy 340:75-3-14, Item D to Exh. 3.*
- j. Conduct and document unannounced random searches of both youths and facility units.
- *OJA and Rader already have policies in place. See OJA Policy P-35-03-08, Rader Policy RC30100.6, Items J & K to Exh. 3.*
- k. Implement adequate search procedures for youths returning from vocational programs, visits and off campus activities.
- *Procedures are already in place. See OJA Policy P-35-03-35, Rader Policy RC30100.6, Items B and E to Exh. 3.*
- l. Establish and document regular inspection mechanisms to monitor the proper by staff of tools hazardous chemicals and cleaning agents, and inventories.
- *Policy already in place. See Rader Policy RC30100.15 & RC30200.02. Item L & M to Exh. 3.*
- m. Review contraband incidents and establish corrective actions including staff training and accountability for complying with required security practices.
- *In addition to responses above, see specifically response to 1i.*
- n. Institute a system of review to analyze data to target problem areas to prevent future occurrences.
- *See response to 1i.*
- 3. To remedy the risk of future unconstitutional suicides and self harm, the United States requests at a minimum, that the Defendants to do the following:
 - a. Immediately, and periodically, provide all direct care, medical and mental health staff with adequate suicide and self harm prevention training which stresses juvenile suicide research, potential predisposing factors to self-harm, high risk suicide periods, and warning signs and symptoms.

- *See OJA policy on Suicide Prevention (P-35-07-12) and Rader policy on suicide prevention/precaution and intervention programs (RC40300.34). See Exh. 3 at p. 7 and Items N and O to Exh. 3. Further, all Rader staff have been trained on these policies. Exh. 10 at p. 258, ls.18-23.*
- b. Increase communication and documentation between staff regarding youths on suicide precautions.
- *The policies referenced in 3a require that a suicide watch log be maintained on all youth on suicide watch.*
- c. Perform routine inspections to ensure that suicidal youths are housed in suicide-restraint rooms and do not have access to suicide hazards such as broken tiles.
- *OJA has a System Review Team which inspects facilities including Rader on a regular basis.*
- d. Ensure that mental health staff perform daily assessments of youths on suicide performance
- *The policies referenced in 3a mandate such assessments.*
- e. Require unit managers to closely review Suicide Precautions Observations records to ensure that direct care staff are observing suicidal youths as required.
- *The suicide policies referenced in 3a require such a review.*
- f. Require mental health care staff to review proposed youth disciplinary measures and cease punishing youths for attempted suicide, self-harm and other indicators of mental health problems.
- *Mental Health care providers do review all proposed disciplinary measures to assure the youth are not punished for attempted suicide, self harm and other indicators of mental health. While the form "Major Rule Violation" may be used to document this behavior and punishment recommended. Such actions are reviewed by the mental health staff before such punishment is imposed. Exh. 10 at p.245, 1.3-p.252, 114. Further as was discussed in response to DOJ's specific factual incidents, if and when punishment is imposed, it usually involves a minor consequence such as early to bed (EBT).*
- g. Ensure that youths who indicate that they may engage in self harm receive prompt and adequate treatment from a qualified mental health professional.
- *Aside from the specialized units currently on site at Rader, OJA has placed a request to transform its employee training center in Norman, OK to a twenty bed residential treatment center to be staffed by qualified mental health professional dedicated to treating juveniles in*

OJA custody. OJA has joined with the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) to request additional funding to transform another 10 residential in-patient beds in this facility. See Exh. 3 at p. 8.

CONCLUSION

DOJ has utterly failed to meet its burden that a mandatory preliminary injunction is necessary at this time. It has failed to establish that Defendants are engaged in a pattern, practice or custom that violates the constitutional rights of the youth at Rader. It has failed to establish that Defendants are indifferent to the plight of the Rader youth and/or that they are failing to provide reasonable care. Finally, OJA has taken steps and continuing to take action to improve the treatment, conditions and security at Rader. As such, Defendants respectfully request this Court deny DOJ's Motion for Preliminary Injunction.

Respectfully submitted,

s/ Kindanne C. Jones

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CERTIFICATE OF SERVICE

I hereby certify that on September 17, 2007, I electronically transmitted the foregoing document to the Clerk of Court using the ECF System for filing and transmittal of a Notice of Electronic Filing to the following ECF registrants:

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